Patient Number: __________________ Date: _____________

CENTER FOR EYE HEALTH, INC.
PATIENT INFORMATION

Name _____________________DATE OF BIRTH_________AGE________________
Last first middle

ADDRESS: _________________CITY__________STATE______ ZIP ____________
HOME PHONE ___________OCCUPATION ______________BUS PHONE _______
SEX ___M MARITAL STATUS ____________CELL PHONE # ______________
___F SOCIAL SECURITY #___________

PERSON TO CONTACT _____________________PHONE NUMBER ____________
REFERRED BY: _______________FAMILY PHYSICIAN ______________________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ______________SECONDARY INS. _______________
SUBSCRIBER NAME: _____________________ SUBSCRIBER NAME:_____________
SUBSCRIBER DOB: _______________________SUBSCRIBER DOB: _____________

ADDRESS OF INSURANCE ____
POLICY #: __________________________ GROUP#: ______________________________
COMPANY NAME: ___________________COMPANY ADDRESS: __________________

AUTHORIZATION: ____

REASON FOR TODAY'S VISIT: ____

WORKMEN'S COMPENSATION CLAIM – EMPLOYER ___________________________
DATE OF INJURY: ______________ ADDRESS ____________________________
INSURANCE COMPANY ____
FOR ACCIDENT CLAIMS: ATTORNEY ____________________________________

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO THE CENTER FOR EYE HEALTH, INC. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, BALANCES AND/OR COPAYS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MY INSURANCE.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS NECESSARY TO PROVIDE MEDICAL CARE, AND FINDINGS TO REFERRING PRACTITIONERS AND CONSULTANTS.

SIGNATURE ________________________________DATE __________________________